

# What causes stigma?

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In Greek society, *stizein* was a mark placed on slaves to identify their position in the social structure and to indicate that they were of less value. The modern derivative, *stigma*, is therefore understood to mean a social construction whereby a distinguishing mark of social disgrace is attached to others in order to identify and to devalue them. Thus, stigma and the process of stigmatization consist of two fundamental elements, the recognition of the differentiating 'mark' and the subsequent devaluation of the per-

son. Throughout history and in practically every culture, groups of persons, including mental patients, have been stigmatized. The reasons for this remains obscure, but how it is sustained and its deleterious impact on the victims is better known, as Corrigan and Watson indicate.

Although the Greeks did not seem to have stigmatized the mentally ill as such, they nevertheless thought that being mentally ill carried a connotation of shame and weakness of character. These beliefs are still found in many contemporary societies that consider being mentally ill as a shameful condition that causes the person or the family to lose face. In some cultures, to have a mentally ill relative could damage the possibilities of advancement of the other members of the family and might even harm the marriage prospects of a young daughter or sister. In those cultures, mental illness not only causes problems to the sufferer but it also has extreme negative connotations to the family. Hence, people do not seek treatment and either hide the symptoms or, when these are too obvious, the family hides the person in the home or sends the person to far away hospitals or locked up asylums (1). In a similar way, families hide the fact that a relative has committed suicide.

Corrigan and Watson describe in their paper how stigma has two major components: a *public* one, or the reaction that the general population has to people with mental illness, and *self-stigma*, or the prejudice that people with mental illness tend to turn against themselves. Furthermore, these authors differentiate three concepts in the understanding of stigma: *stereotypes*, defined as positive, but more frequently, negative social knowledge structures that predetermine our attitudes; *prejudice*, which is the cognitive and affective response that develops when a person or group endorse negative stereotypes; and *discrimination*, which is the behavioral reaction once prejudice sets in. To these very pivotal concepts three others should be added that help perpetuate stigmatizing attitudes: visibility, controllability and impact. The more *visible* the stigmatizing mark or condition, the more the public perceive it to be under the *control* of the

bearer, and the more the possibilities that it will have an *impact* on others, the strongest the stigma, the prejudice and the discriminating behaviors (2).

Unfortunately, our understanding of *what* stigma is and how it develops is not matched by our knowledge of *why* it develops, although a model posits that the original functional impetus is an initial perception of tangible or symbolic threat (3). Tangible threats are those that pose a risk to material or concrete goods and symbolic ones are those that threaten beliefs, values, ideology or the way in which a group ordains its social, political or spiritual domains. Two most enduring threats would help originate and perpetuate the stigma of mental illness in many societies. The first considers that mental illness is under the control of the sufferer and hence that the patient is lazy and cannot hold a regular job (4), thus becoming a tangible threat to beliefs on self sufficiency and communal sharing of hardships and rewards. The second paints the mental patient as unpredictable and dangerous, hence representing a material threat to personal security. While the first threat fails to recognize that there is a spectrum of disability in mental illness not unlike that found in any other type of illness, the second is based on sensationalistic media and misleading measures of community risk (5).

While, as Corrigan and Watson point out, knowledge of the social dimensions of stigma and the impact of stigma and discrimination on mental patients has begun to accumulate, much remains to be known specially on models to understand self-stigma and the development of adequate instruments to measure it. Similarly, while programs to combat the stigma of mental illness are now well organized in many countries, what are effective interventions and how and to what groups should they be targeted to make them more efficient are areas that require further research and elucidation.

## References

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